STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 100070-001**

v

Blue Care Network of Michigan
Respondent
_____/

Issued and entered
this 14th day of October 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On September 8, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On September 15, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue in this matter can be resolved by analyzing the terms of the Petitioner's group health care coverage with Blue Care Network (BCN), including the certificate of coverage and its related Healthy Living rider (the rider). It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

Effective January 1, 2008, the Petitioner and her family were conditionally enrolled in BCN's Healthy Blue Living Program which is described in the rider:

> **Healthy Living Program** is the BCN coverage program designed to promote or maintain good health and/or prevent disease or the progression of disease for Members in the Program. The Program rewards Members that maintain or adopt healthier behaviors by making lower copayments, and/or coinsurance and deductibles available to those Members.

BCN terminated the Petitioner's enrollment in the enhanced Healthy Blue Living plan on July 4, 2008, and returned her to the standard plan because her family had not met the criteria for continued participation in the enhanced plan.

The Petitioner unsuccessfully appealed her termination from the enhanced plan through BCN's internal grievance process and received its final determination letter dated August 25, 2008.

III
ISSUE

Did BCN properly deny the Petitioner and her family continued coverage in the enhanced Healthy Blue Living program?

IV
ANALYSIS

Petitioner's Argument

The Petitioner wants her coverage in the Healthy Blue Living program restored as of July 5, 2008. She says they tried to complete the requirements to remain in the program but "my husband had a follow-up visit with his PCP [primary care physician] which he unknowingly missed because the doctor never made a reminder call prior to the scheduled visit."

The Petitioner says that she and her husband have worked hard to maintain their healthy lifestyle and believe it is "extreme" to be terminated from the enhanced benefits plan for missing an appointment. She explained in a September 3, 2008, letter that she will be unable to see a doctor now because her copay will be $30.00 and that her husband's pharmacy copayments will be around $120.00 per month and she is the only one currently working. She

says she has "used the services of Healthy Blue to stop smoking, control my cholesterol, prevent unwanted pregnancies and maintain my allergies."

The Petitioner believes her family is being punished for missing a follow-up visit to the PCP and will not be able to maintain their good health if they are removed from the enhanced benefits plan. She wants to be returned to the enhanced program.

Respondent's Argument

In its August 25, 2008, final adverse determination, BCN offered this explanation for not restoring the Petitioner to the enhanced benefit program:

> The required documentation to remain in the Enhanced benefit level was not submitted within the required time period. Your husband did not keep his follow-up appointment with his primary care physician…. On his original Health Qualification Form, which was dated February 20, 2008, it was noted that a follow-up visit, was required within three months [i.e., by May 20, 2008]. Therefore, we have maintained our decision and your contract will remain in the Standard benefit level. You may re-apply for our enhanced benefit at your next open enrollment.

BCN says that the Petitioner was enrolled in the enhanced benefits program on January 1, 2008. The original Health Qualification Form (HQF), dated February 20, 2008, informed the Petitioner's husband that he had to have a follow-up visit with his PCP within 90 days (i.e., by May 20, 2008) to complete the HQF.

He was also notified of this requirement in a congratulatory letter dated March 7, 2008. BCN further says that the deadline was extended by a 45-day grace period which would have allowed the follow-up visit by July 4, 2008.[1]

Since the Petitioner's husband did not meet the deadline for the follow-up visit, BCN contends that its decision to place the Petitioner under the standard coverage was correct.

[1] The grace period is an internal policy that is not mentioned in the rider. Nothing in record shows that anyone followed-up with the Petitioner's husband to reschedule the missed appointment or alerted him that he had until July 4, 2008, to reschedule his appointment with his PCP.

Commissioner's Review

The issue in this case is whether BCN properly denied continued coverage in its Healthy Blue Living rider's enhanced benefit program.

The rider describes the requirements for continuing coverage in the Healthy Blue Living program after 90 days. The rider includes the following provisions:

> **HOW TO EARN THE HEALTHY LIVING ENHANCED BENEFITS IN THE FIRST YEAR OF ENROLLMENT**
>
> Upon enrollment each Healthy Living Eligible Member will receive Enhanced Benefits for a 90-day period. To continue receiving the Enhanced Benefits each Healthy Living Eligible Member must take the following steps:
>
> 1. Within 90 days of enrollment each Healthy Living Eligible Member must complete a Health Risk Assessment (HRA) and a Healthy Living Enrollment Form which will assess the Member's medical condition and/or lifestyle behavior in relation to the following areas:
>
>   - Blood pressure
>   - Smoking
>   - Cholesterol
>   - Blood sugar
>   - Weight
>   - Alcohol use
>
> 2. In order to earn the Enhanced Benefits, Healthy Living Eligible Members must achieve a score of 80 points or more on the Healthy Living Enrollment Form. Scores are based upon a combined assessment of the Member's current medical condition and/or lifestyle behavior and the Member's commitment to comply with the conditions of programs and behaviors recommended by their primary care physician and BCN. The results of the Healthy Living Enrollment Form must be reviewed with and signed by the Member's primary care physician. The results must be submitted to BCN within the 90-day time period.
>
> 3. If both Healthy Living Eligible Members have Healthy Living scores of 80 points or more as a result of their current medical conditions and/or lifestyle behaviors, all members on the contract will automatically continue to receive Enhanced Benefits until the date for Reassessment recommended by the Members' primary care physicians.

* * *

> 5. At the time of the Member's Reassessment, the Member must evidence to the Member's primary care physician that he or she has maintained or achieved a Healthy Living score of 80 points in order for the entire contract to qualify for Enhanced Benefits.

Health maintenance organizations like BCN are permitted to offer wellness programs like the one here that provides for reduced copayments, coinsurance, or deductibles if conditions are met. See MCL 500.3426. As a condition of remaining in the BCN Health Living enhanced benefit plan, eligible members must meet the requirements of the rider.

The Petitioner's husband was required to have the Healthy Living Enrollment Form, submitted on February 20, 2008, reassessed by his PCP within 90 days. The rider says:

> The results of the Healthy Living Enrollment Form must be reviewed with and signed by the Member's primary care physician. The results must be submitted to BCN within the 90-day time period.

When BCN received the Petitioner's husband's completed qualification form and health risk appraisal, it notified him that he needed to have a follow-up appointment with his PCP and warned that he would be moved to the standard benefit plan if he did not do so within the required 90 day time period. The Petitioner acknowledges that the appointment was made and that her husband inadvertently failed to keep it. The PCP did not review and sign the Petitioner's husband's Healthy Living Enrollment Form as required by the rider.

The Commissioner concludes that the Petitioner's husband did not follow the requirements of the Health Living program and therefore BCN's decision to place the Petitioner and her family in the standard benefit plan was consistent with the rider. The Petitioner may reapply for the enhanced benefits plan at the next open enrollment.

V
ORDER

The Commissioner upholds BCN's August 25, 2008, final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this

Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.